CHAIN OF CUSTODY FORM INSTRUCTIONS

Current Version of Form: 03/2016


CHAIN OF CUSTODY FORM

OTS – SOUTHAVEN
LABCORP
1120 MAIN STREET
SOUTHAVEN, MS 38671
3000

Customer Service: 800-444-7997

0973388894

STEP 1: TO BE COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address and I.D. No.
RN EXPERTISE
691 DOUGLAS AVE/STE 101
ALTAMONTE SPRINGS FL 32714
407-865-6544
FAX: 407-865-7993
Location

B. MRO Name, Address, Phone and Fax No.
RN EXPERTISE
ATTN: DAVID PARSONS, M.D.
691 DOUGLAS AVE/STE 101
ALTAMONTE SPRINGS FL 32714
407-865-6544 FAX: 407-865-7997

C. Donor SSN or Employee I.D. No.

D. Reason for Test: ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Periodic ☐ Other

E. Collection Site Address:

Collector Phone No.
Collector Fax No.

F. Donor Identification Verified By: ☐ Photo I.D. ☐ Employer Representative

STEP 2: TO BE COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100°F? ☐ Yes ☐ No, Enter Remark Below Split Specimen Collection ☐ Yes ☐ No

REMARKS:

STEP 3: TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

STEP 4: TO BE COMPLETED BY COLLECTOR AND DONOR

G. Daytime Phone No. ( ) Evening Phone No. ( ) Date of Birth / /

H. TEST(S) REQUESTED BY EMPLOYER:
( )- PROFILE 1- 5 PANEL
( )- PROFILE 2- 9 PANEL
( )- PROFILE 3- BLOOD ALCOHOL ONLY

I authorize the collection of this specimen for the purpose of a drug screen. I acknowledge that the specimen container(s) was/were sealed with tamper-proof seal(s) in my presence, and that the information provided on this form and on the label(s) affixed to the specimen container(s) is correct. I authorize the laboratory to release the results of the test to the company identified on this form or its designated agents.

(PRINT) DONOR'S NAME (FIRST, MI, LAST) SIGNATURE OF DONOR INITIAL / / MONTH DAY YEAR

STEP 5: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified on this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X
Signature of Collector
Time of Collection AM PM
(PRINT) Collector's Name (First, M, Last)
(Date (Mo/Day/Yr.))

SPECIMEN BOTTLE(S) RELEASED TO:
Name of Delivery Service Transferring Specimen to Lab

RECEIVED AT LAB:
X
Signature of Accessioner
PRINT Accessioner's Name (First, M, Last)
Date (Mo/Day/Yr.)

Primary Specimen Bottle Seal Intact
☐ Yes
☐ No, Enter Remark Below

SPECIMEN BOTTLE(S) RELEASED TO:

Printed: 06/10

CONTAINER SEAL
OTS – SOUTHAVEN
3000
0973388894
0973388894
0973388894
A / / DATE DONOR'S INITIALS
B SPLIT / / DATE DONOR'S INITIALS
NOTE POSITION OF BARCODE STARTS AT BOTTOM OF CONTAINER AS SHOWN HERE

COPY 1 - LABORATORY

PURPOSE:

- Used to have all employees involved in accidents tested
- To be in compliance with the Post Accident Drug Test Policy

PREPARATION:

- Provide the injured worker a blue Chain of Custody form to take to the testing vendor
- Check the block marked ‘OTHER’
- Write Workers’ Comp in the blank next to ‘other’

DISPOSITION:

- The cost of the post-accident drug testing will be paid on the workers' compensation claim

- By checking the 'other' box and writing workers' compensation in the blank, RN Expertise will know to bill Sedgwick directly for the testing